Purpose · Services · Process · People

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for Group Health Cooperative

Chart Review Targets for GHC 2010

- Number of total appropriate members – 57,155
- Number of targeted members overall – 23,293
- Number of GHC members / internal docs – 17,121
- Number of targeted members who saw a doc – 21,221
- Number of total providers with a patient match – 1,040
- % of PCP provider with patient match – 90.38%
- % of patients matched to PCP provider – 99.36

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2010 Chart Review Results

- Chart Review Cycle – 42 Days
- Number of Charts Reviewed – 15,875
- Number of Physicians Reviewed – 524
- Number of Members with Finds – 4,578
- Top finds validated
  - Old MI
  - Polyneuropathy
  - Vascular Disease
  - CKD
  - COPD

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A Few Coding Tips

Coding Cancer

- There were instances of metastatic disease that were not coded during 2010
- There were instances of coding for active cancer when there was no apparent active treatment

Ex.: Meningioma was found, removed diagnosis remained active in documentation

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Alcohol Dependence vs. Abuse

- These diagnoses are mutually exclusive
- Alcohol abuse can lead to alcohol dependence
- Alcohol dependence remits but does not resolve

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Diabetes with Complications

- Many diabetic patients were seen and peripheral vascular disease was documented at encounter but not tied to diabetes
- Diabetes and PVD were rarely tied together
- Diabetes and renal failure were documented but not tied together

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Acute Diagnoses That Resolve

- AAA – repaired but still documented as active
- Fractures, including vertebral

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PVD – 443.9 is not the same as…

Occlusion of the Carotid Artery without infarct -433.10

Occlusion of the Carotid Artery with infarct – 433.11

Occlusion and stenosis of precerebral arteries -433

"Small vessel disease" is PVD

"Venous insufficiency" is not

"Coronary microvascular disease" or

"Small vessel *heart* disease" are not

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Did You Mean…

- PVD when you said vascular or venous insufficiency?
- CKD when you said renal insufficiency?
- Major Depression in remission when single episode remains active over time?
- Cerebral or carotid artery stenosis when you said PVD?
- Afib when you said Afib – or is it resolved with a pacer or controlled with meds or is it underlying with a pacer
- Atherosclerosis when you said "hardening of the arteries" or "plaque in the aorta"

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Common Terms for Clinical Diagnoses

- Hardening of the Arteries or Plaque in the aorta /atherosclerosis
- Community Acquired Pneumonia / was it aspiration
- Alcoholism / Alcohol Dependent
- Hx Alcoholism long time ago / Alcohol Dependence in Remission
- Depression / Major Depression / in Remission
- PVD / signs and symptoms are there

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Coding Systemic Conditions

"Certain diagnoses such as hypertension, Parkinson's disease, and diabetes mellitus are examples of systemic diseases that should be coded, even in the absence of documented active intervention. "

AHA Coding Clinic

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Coding Chronic Conditions - hosp

"If there is documentation in the medical record to indicate that the patient has COPD, it should be coded. Even if this condition is listed only in the history section with no contradictory information, the condition should be coded. Chronic conditions such as, but not limited to, hypertension, Parkinson disease, COPD, and diabetes mellitus are chronic systemic diseases that ordinarily should be coded even in the absence of documented intervention or further evaluation. Some chronic conditions affect the patient for the rest of his or her life and almost always require some form of continuous clinical evaluation or monitoring during hospitalization, and therefore should be coded."

The AHA Coding Clinic

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Chronic Conditions – Outpatient & physician

"For outpatient encounters/visits, chronic conditions that require ***or affect*** patient care treatment or management should be coded."

"Code all documented conditions that coexist at the time of the encounter/visit and require ***or affect*** patient care treatment or management. Do not code conditions that were previously treated ***and*** no longer exist."

The AHA Coding Clinic

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Probable, Suspected, Rule Out

Conditions that are integral to a disease process should not be assigned as additional codes. This guideline applies to all healthcare settings.

Conversely, conditions that ***may not*** be associated routinely with a disease process ***should be assigned additional codes***. A solid understanding of the disease process is necessary.

AHIMA

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Probable, Suspected, Rule Out Inpatient

In the ***inpatient setting***, if a diagnosis documented at the time of discharge is qualified as “probable,” “suspected,” “likely,” “questionable,” “possible,” or “rule out,” the condition ***should be coded*** as if it existed or was established.

AHIMA

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Probable, Suspected, Rule Out Outpatient /Physician

In the ***outpatient setting*** (including physician offices), diagnoses documented as “probable,” “suspected,” “questionable,” or “rule out” ***should not be coded*** as if they are established. Rather, the conditions should be coded to the highest degree of certainty for that encounter, such as symptoms, signs, abnormal test results, or other reason for the visit. ***AHIMA***

Based on *Coding Clinic for ICD-9-CM* 17, no. 1, it is appropriate to code based on the physician documentation available at the time of code assignment.

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Incidental Findings

Incidental Findings

Incidental findings should never be listed as primary diagnoses. If reported, incidental findings may be reported as secondary diagnoses by the physician interpreting the diagnostic test.

Medicare Claims Processing Manual – Ch 23 (Rev.1, 10-01-03)

Unrelated Coexisting Conditions/Diagnoses

Unrelated and coexisting conditions/diagnoses may be reported as additional diagnoses by the physician interpreting the diagnostic test.

—Medicare Claims Processing Manual – Ch 23 *(Rev. 1, 10-01-03)*

"The diagnosis documented by the pathologist or radiologist is the condition representing the highest degree of certainty for that visit. Any documented symptoms or conditions that are not routinely associated with the definitive diagnosis should be assigned additional codes."

—*Coding Clinic for ICD-9-CM 17*, no. 1

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Coding Symptoms – OP /Phys

Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when an established diagnosis has not been confirmed by the physician. However, this means that when a definitive diagnosis has been established for that encounter, the established diagnosis should be coded.

Any conditions, including signs and symptoms, that are not routinely associated with the definitive diagnosis should be assigned as additional codes.

Diagnostic Coding and Reporting Guidelines for Outpatient Services

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"Appears to be" vs. "Evidence of"

Coding Clinic states that physician documentation of "appears to be" qualifies as an uncertain diagnosis, but that the statement "evidence of" is not uncertain.

Therefore, "**evidence of**" a diagnosis should be coded and reported as a **definitive** diagnosis in the **outpatient** setting, whereas the statement "appears to be" as applied to a diagnosis cannot be reported for outpatients.

Coding Clinic 3rd Quarter 2009 p.7

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Hypoxia – What Medicare Says

- $PO_2 \leq 55$ mm HG, or an arterial oxygen saturation ≤ 88% on room air at rest;
- $PO_2 \leq 55$ mm HG or an arterial oxygen saturation ≤ 88% on room air during sleep (prescribed oxygen during sleep);
- A decrease in arterial PO_2 measuring more than 10 mm Hg or a decrease of more than 5% in arterial oxygen saturation during sleep (prescribed oxygen during sleep);
- $PO_2 \leq 55$ mm HG or an arterial oxygen saturation ≤ 88% taken during exercise (prescribed oxygen during exercise).
- Arterial PO_2 between 56-59 mm Hg or arterial blood oxygen saturation of 89% and evidence of: Pulmonary hypertension or cor pulmonale, determined by measurement of pulmonary artery pressure, gated blood pool scan, echocardiogram, or “P” pulmonale on EKG.

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Old MI

"Old myocardial infarction, is a history code and should be reported to identify a "healed old MI" whether the patient is currently experiencing problems of not. An old myocardial infarction is coded because it is significant and affects the management of the patient. The note under code 412 mentioning, "currently presenting no symptoms" refers to symptoms related to the previous old myocardial infarction, not cardiac symptoms in general." *Coding Clinic for ICD-9-CM, Second Quarter 2003, Page 10*

In many instances an EKG report with the diagnosis documented on the report and a physician signature is acceptable documentation to code a diagnosis of 412 (Old MI)

CSSC RADV FAQ's 4/2005

Coding Clinic for ICD-9-CM 17, no. 1, clarifies that it is appropriate for coding professionals to use physician interpretations of tests as a basis for accurate code assignments in the outpatient setting.

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Chronic Kidney Disease

- Risk dollars assigned for MA - Avg $2,700 PMPY
- 45% of people over age 65 have CKD
- Increases with:
  - Hypertension
  - Diabetes
  - Cardiovascular disease
- Cost of CKD in Medicare

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Cost of CKD Nationally - 2009

	All CKD	585.1–2	585.3	585.4–5	Unk/unsp
Inpatient/outpatient					
Inpatient					
Medical DRG	2,699.27	2,387.89	2,573.43	3,045.93	2,756.32
Surgical DRG	2,758.89	2,440.22	2,672.09	3,609.14	2,671.49
Other DRG	3,008.03	2,622.84	2,697.00	4,158.71	3,011.24
Inpatient pass-through	182.30	152.21	161.81	250.10	185.25
Outpatient					
OP dialysis	3.54	0.07	0.50	27.14	0.60
OP EPO	56.05	17.22	78.60	177.83	18.89
IV vitamin D	0.33	0.00	0.03	2.78	0.01
IV iron	3.54	1.57	4.64	11.94	1.16
Other injectables	131.47	110.35	106.33	107.92	157.64
OP surgery	222.70	198.55	216.28	270.14	220.02
OP radiology	313.59	272.06	299.10	271.09	340.73
OP laboratory	245.22	204.19	263.35	344.75	216.69
OP pathology	14.48	14.97	14.65	14.40	14.30
Emergency hospital	119.79	107.87	114.85	136.82	121.17
Clinic	87.30	71.67	86.39	97.42	88.26
PT/OT	205.28	184.43	168.22	207.40	233.28
Pharmacy	42.18	42.68	43.19	46.45	40.40
Supplies	214.57	196.63	226.11	228.90	206.61
Other outpatient	273.27	240.58	280.05	300.29	268.10
Skilled nursing facility	2,311.40	1,842.95	1,925.59	2,819.44	2,532.06
Home health agency	1,497.93	1,408.63	1,323.40	1,776.77	1,564.42
Hospice	790.10	603.21	519.06	1,146.87	920.00
Total	15,181.23	13,120.80	13,774.65	19,052.21	15,568.65

http://www.usrds.org/2011/view/v1_06.asp

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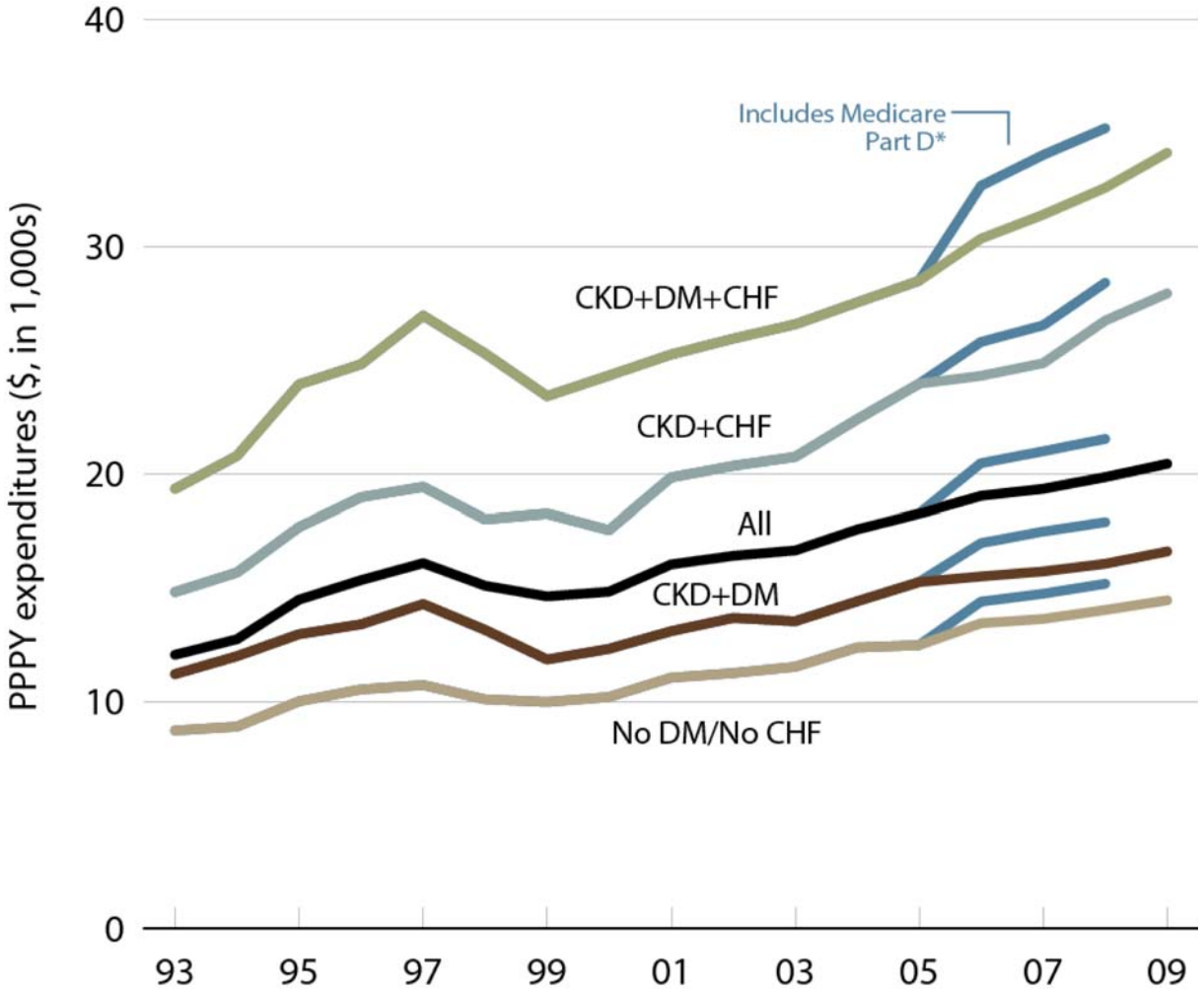
Total Cost of CKD in Medicare by At-Risk Group



http://www.usrds.org/2011/view/v1_06.asp

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Incentives, Queries and Changing Physician Behavior

- Incent for time, cost or for better documentation, be specific -but not to HCC's
- There are very specific rules around queries to avoid leading questions etc. Pay strict attention as you develop policies
- If it doesn't save time, measurably improve care or create revenue, studies show it's difficult to do

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The HCCs – Should We Tell Them?

- Good documentation and coding is all inclusive and not just HCC related
- Coders are trained to code what physicians specifically write and most good, experienced coders are trained to code for billing purposes (CPT and DRG) – ICD 9's are different
- Coding for the HCC's is important for payment
- Coding everything is important for reporting
- Documenting everything is good for quality care

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New RADV Methodology Announced

- CMS will use the new methodology for the next round of RADV contract-level audits. These audits will likely commence in the fall of 2012 and will be conducted on payment year 2011.
- CMS will calculate a payment error rate based on a sample *of up* to 201 beneficiaries. CMS will then extrapolate the error rate to the entire RADV-eligible population.
- Previously, CMS only allowed one date of service for each CMS-HCC being validated during RADV. ***The new methodology allows for multiple medical records for each CMS-HCC being validated.***
- The RADV audit dispute and appeal processes will continue to use the one date of service policy. CMS will provide additional information to each plan selected for RADV.
- CMS will include a FFS adjuster to account for differences in RADV documentation standards and documentation standards used to develop the risk-adjustment model. The FFS adjuster will reduce the recovery amount.
- CMS has not specified the overall impact of the FFS adjuster. They plan to calculate the FFS adjuster by doing a RADV-like audit of FFS medical records.
- CMS estimates $370M in recoveries the first year using the new methodology.

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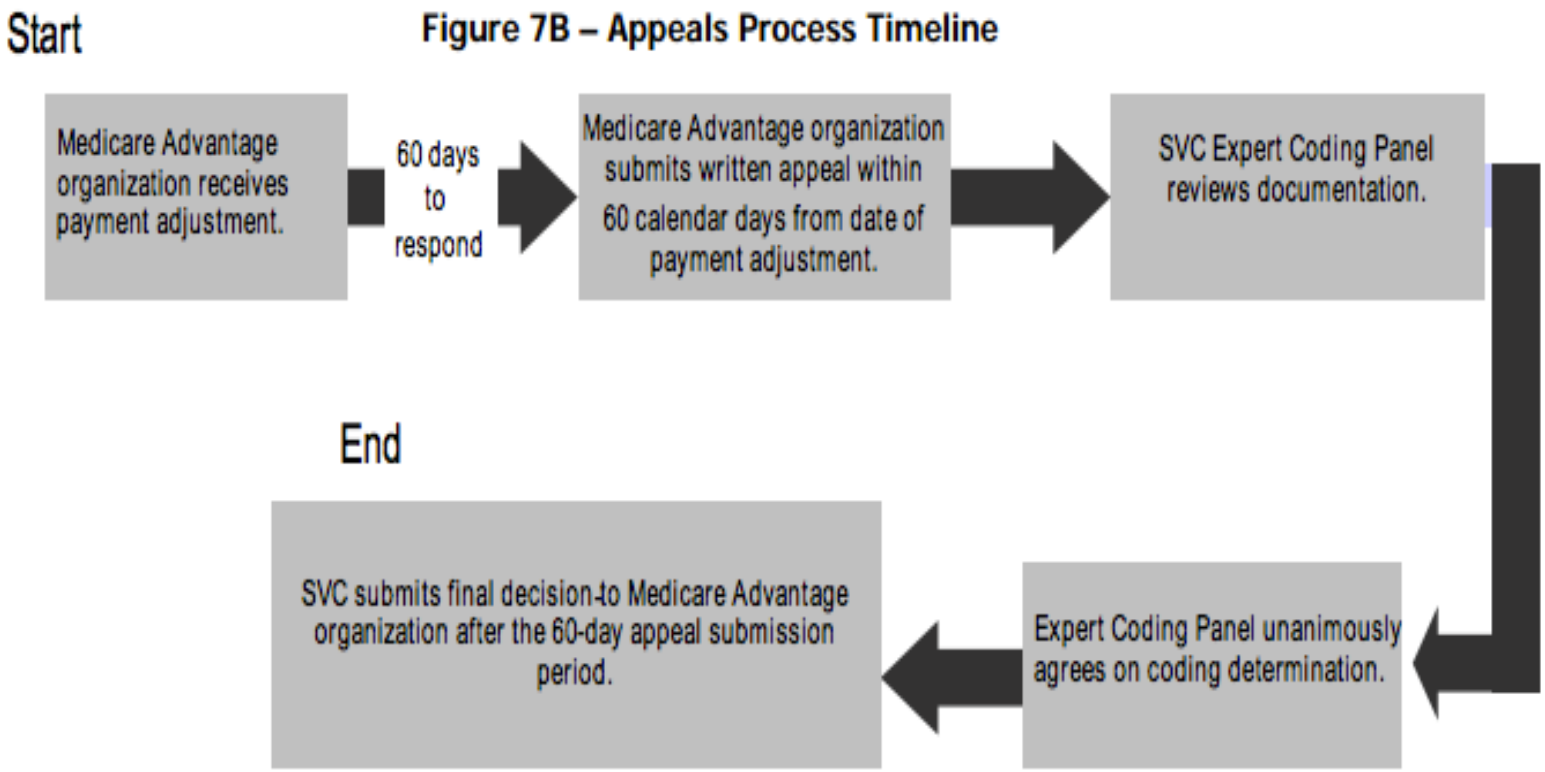
RADV - PROCESS



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Thank You

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